STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125056	A. BUILDING: _____ B. WING _____	08/30/2019

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HALE MAKUA HEALTH SERVICES	1540 LOWER MAIN STREET WAILUKU, HI 96793

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4 000	Initial Comments A relicensure survey was conducted by the Office of Health Care Assurance (OHCA) on August 30, 2019. the facility was found not to be in substantial compliance with Chapter 11-94.1. Hawaii Administrative Rules, Nursing Facilities. Survey Dates: August 27, 2019 through August 30, 2019. Survey Census: 73 Sample Size: 20	4 000		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observation and interview the facility failed to provide one Resident (R)4 sampled with privacy by exposing the resident's urinary catheter bag in view of the window and door to the residents room. The urinary catheter bag was not covered with a bag or other item to provide the resident with appropriate privacy. This	4 115	4 115 Resident rights and facility practices Corrective Action The facility will ensure that we honor all resident's rights to dignity while residing in the facility. All residents have a right to a	10/4/19

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4 115	Continued From page 1 deficient practice violated the resident's right to dignity while residing in the facility. In addition, the facility failed to ensure their staff only spoke English in the facility. As a result, this was not respectful to the residents as the residents did not understand what was being said, and if it was about them. This deficient practice has a potential impact to affect all residents living in the facility. 1. During an observation on 08/27/19 at 10:45 AM in room 145 (R4's room) noted a urinary catheter collection bag in view of the window and front door. The catheter collection bag appeared to be on the left side of the bed (in view of the door) 3/4 full with bright yellow urine. No cover was in place over the bag. During an interview with Licensed Practical Nurse (LPN)66 on 08/27/19 at 12:48 PM while standing in the doorway looking into room 145 at the Foley catheter bag hanging from the bed asked LPN66 when do staff cover the catheter bag for the resident? LPN66 replied, no need because she is in her room. We would cover the bag when we take the resident out of her room. Discussed with LPN 66 that the catheter bag is in clear view of the window and door and whether this violates the residents privacy. LPN66 responded well, we should close the curtain. During an interview with the Charge Nurse (CN)96 at 03:30 PM, discussed the resident's privacy regarding the urinary catheter bag being exposed to people who pass by room 145. CN96 responded I will take care of this so that the resident's urinary catheter bag is covered. 2. During the group interview with the resident council members on 08/28/19 at 10:22 AM, the	4 115	dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. Resident R4's urinary catheter bag was covered with a privacy bag on 08/27/19. This facility will ensure that staff speak in a language that the residents can understand. All staff education regarding resident dignity will be completed by 10/04/19. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. Responsible Person The Administrator and Director of Nursing will be responsible for on-going compliance and safety. Systemic Changes and Monitoring All staff will be in-serviced 10/04/19 on Resident Rights and Dignity. Certified Nurse Aides will ensure all urinary catheter bags are covered with dignity bags. Neighborhood Supervisors will conduct	

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4 115	Continued From page 2 residents voiced and confirmed that the facility staff are speaking amongst themselves in Filipino. Three of the residents confirmed they have seen it and heard it. The residents affirmed that it was okay for a staff to speak to a resident who spoke in that resident's native dialect however, they stated the concern was that staff are speaking to each other in Filipino and not to a resident who speaks it. The resident council agreed that since they did not know what the staff were saying in Filipino, and/or if it could be about them personally, they found this to be disrespectful. On 08/29/19 at 08:54 AM, during an interview with the social services assistant (SSA), he stated the dominant language to be spoken in the facility is English in the presence of residents. The SSA said unless it involves the resident and staff communication whereby the resident prefers to speak in their native tongue, "the expectation of all staff is to speak English."	4 115	weekly audits on all residents with catheter orders for the next 90 days or until 100% compliance. Interdisciplinary team will conduct monthly Facility Focus Rounds to ensure that resident rights are being addressed. Activities Director/Social Service Designee will discuss resident rights as it relates to language in resident council each month for the next 90 days or until 100% compliance. Any and all issues will be resolved immediately and reported to daily stand up meeting as well as discussed monthly at Quality Assurance Performance Improvement Committee (QAPI) meetings. Date of Correction Compliance will be met by 10/04/19 and on an ongoing basis.	
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention;	4 136		10/4/19

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4 136	Continued From page 3 (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: I. Based on observation, interview, record review (RR), and Policy review, the facility failed to prevent two of six Residents (R)49 and R30 investigated for accidents from multiple falls with one fall (R49) resulting in major injuries. The deficient practice caused R49, who is a 100 year old female resident with a severe cognitive impairment at high risk for falls to suffer harm by sustaining multiple facial fractures that resulted from being left to sit in a wheelchair unsupervised and R30 has had eight documented falls and is at a potential risk for major injuries. In addition, the facility failed to accurately assess the safety of a third Resident (R)40 while smoking. This deficient practice has the potential to cause serious burns and injury to the resident with contractured fingers who was smoking unsupervised and without safety devices to prevent smoking accidents like a an apron. Findings include: 1) During an observation on 08/27/19 at 12:09 PM at the dining table in the common area in between room's 143 and 148, R49 was sitting in her wheelchair alone at the table. R49 appeared to have multiple purple marks (bruising) on both lower arms and forehead. A fall alarm was attached to her wheelchair. R49 was moving around in her chair and appeared agitated when she suddenly stood up from the wheelchair and when the chair alarm started to beep very loud	4 136	4 136 Resident care I. Corrective Action This facility will ensure that all resident falls are investigated to prevent falls resulting in major injuries. R49 has an order for physical therapy evaluation and treat on 09/30/19 for positioning. Resident placed on q30 minutes checks for safety indefinitely. IDT to review physical therapy recommendations and q30 minute check audits once complete. R30 has an order for physical therapy evaluation and treat on 09/30/19 for positioning. Resident placed on q30 minutes checks for safety indefinitely. IDT to review physical therapy recommendations and q30 minute check audits once complete. This facility will ensure that all residents who wish to smoke are accurately assessed for safety of smoking on admission, quarterly, and as needed. R40 smoking assessment was completed on 09/10/19. Resident was deemed not	

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4 136	Continued From page 4 she sat back down. During a tour of the Lanai unit on 08/27/19 at 12:26 PM, did not note any signage to indicate potential fall risk outside of any of the individual resident rooms. The facility provided matrix revealed that R49 was listed with a fall with a major injury. RR revealed that R49 is a 100 year old female diagnosed with Alzheimer's dementia who has documented multiple falls in the facility with one fall on 07/09/19 that resulted in multiple facial fractures requiring transport by ambulance to an acute care hospital where she was treated for her injuries. During an interview with the Charge Nurse (CN) on 09/29/19 at 03:32 PM stated that R49 had a fall and was sent to the hospital and diagnosed with multiple facial fractures. After the fall, the director of nursing, (DON), Administrator and Social worker came to the unit to huddle and do a root cause analysis. When asked how to identify a resident at risk for falls since there are no signs outside the rooms to identify those resident's, she responded that there isn't a protocol in place. Clinical notes report reviewed. Fall history: a. 03/07/19; 04:40 AM staff found resident in supine position on the floor next to her bed; no injuries sustained. At 0535 AM, staff responded to the care sense alarm and found resident on supine position near the foot of her bed. R49 sustained a hematoma to left frontal area. b. 03/09/19: R49 was out of bed ambulating without assistance and started to fall. The certified nurse aide (CNA) assisted her to the	4 136	safe to smoke independently. OT evaluation done on 09/17/19 determined that resident is safe to smoke independently with current adaptive devices. Care plan updated to reflect IDT decision to allow resident to smoke independently. Resident smoking supplies to be stored at nurses station. Resident required to use apron while smoking. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. Responsible Person The Director of Nursing and Neighborhood Supervisors will be responsible for on-going compliance of assessment completion, care plan updates and implementation. Systemic Changes and Monitoring All staff in-serviced by 10/4/19 regarding resident Accidents Hazards/Supervision/Devices. IDT will review conduct post fall huddles immediately post fall and implement immediate interventions as deemed appropriate. IDT will review all resident falls within 72 hours to implement any additional necessary immediate	

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4 136	Continued From page 5 floor at 03:10 PM, no injuries. c. 03/14/19 R49 standing up a ambulating on her own with unsteady gait. d. 03/15/19: Restless this evening, standing up from wheelchair, chair, bed; triggering alarm. e. 03//16/19: Witnessed fall at 09:00 AM. CNA noted resident standing from wheelchair. Pushed her bed side table to her left side and started to ambulate two - three steps forward. CNA attending to other resident and unable to assist R49 who fell. No injuries. f. 03/18/19: R49 observed getting up from her wheelchair multiple times during the shift. g. 03/21/19 R49 got up from bed and started calling out loudly. h. 07/09/19 12:25 PM CNA found resident on floor; laying left side. Noted left forearm (LFA) skin tear approx. 2.5 centimeters (cm) skin tear; dressed with steristrip noted with guarding and complaint of pain to LFA. Noted bruising to upper lip; nose bleed to right nare only. Hematoma 7 cm diameter approx. to left cheek with skin tear 2.5 cm in length. Noted small 1 cm cut to left upper eye lid. Approx 3 cm hematoma to mid forehead. R49 was transported by ambulance to the Emergency Department (E). At 05:44 PM received report from ER nurse that R49 will be returning to the facility and that she sustained multiple facial fractures. During an observation of R49 on 08/28/19 at 08:31 AM. R49 laying in bed with eyes closed. Skin tear on her left lower leg. The hospital bed was in the medium position and the mattress was scooped. The call light was under R49 bed out of her reach. Per the clinical notes dated 03/16/19 Power of Attorney (POA) requested use of a lap buddy while R49 is in her wheelchair and foam noodles	4 136	interventions. All staff in-serviced by 10/04/19 on facility P&P on resident smoking. Facility is utilizing assessment in EMR to determine resident smoking safety. Facility smoking policy updated to reflect current changes include use of apron while smoking. Date of Correction Compliance will be met by 10/04/19 and on an ongoing basis. II. Corrective Action This facility will ensure that residents who require dialysis, receive such services consistent with the professional nursing standards of practice, including accurate assessments of the resident's condition to monitor for complications of the arteriovenous fistula (AVF) (an access site in the arm for hemodialysis), specifically after HD treatments. R1 Physical monitor under treatment orders was added on 08/29/19 for monitoring of left AVF for Bruit and Thrill, infection and bleeding every (Q) shift. No residents were identified to have been affected by this deficiency. All residents have the potential to be	

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4 136	Continued From page 6 underneath her bed mattress. "Something, that will keep her safe from falling". Further review revealed the Lap buddy was not implemented. 07/10/19 POA requested for padded floor mats. In spite of the resident having several falls prior to the fall on 07/09/19, floor mats were ordered. Each of the falls staff reported responding to the chair alarm, although when they were able to attend to the resident, she had already fallen. Care plan dated 12/04/15 to present reviewed. Noted the following interventions for risk for fall/ injury. 1. Monitor R49 frequently in case she forgets to call for help. 2. Ensure that R49 is supervised while sitting in her wheelchair or other device. 3. Keep call light secured and within easy reach. R49 was not supervised while in her wheelchair or in her bed when each of the falls occurred. R49's call light was found under her bed on 08/28/19 at 08:38 AM while lying in bed. Facility Falls and Fall Risk, Managing Policy reviewed. Resident-Centered Approaches to Managing Falls and Fall Risk 5. "If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. Monitoring Subsequent Falls and Fall Risk. 3. "If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interveions. During an interview with Licensed Practical Nurse (LPN)90 on 08/30/19 at 08:59 AM to discuss the	4 136	affected by this deficiency. Responsible Person The Director of Nursing and Neighborhood Supervisors will be responsible for on-going compliance to ensure all residents that received Hemodialysis with an AV shunt have appropriate monitoring orders in place. Systemic Changes and Monitoring All staff in-serviced by 10/04/19 regarding monitoring requirements of all residents that received Hemodialysis with an AV shunt. All residents who receive Hemodialysis were reviewed. All residents have monitoring of AVF for Bruit and Thrill, infection and bleeding every (Q) shift in place. Director of Nursing and/or Assistant Director of Nursing will conduct admission reviews of new residents with HD, as well as monthly audits of all residents with HD, to ensure treatment orders are in place each month for the next 90 days or until 100% compliance. Date of Correction Compliance will be met by 10/04/19 and on an ongoing basis.	

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account of R49 fall on 07/09/19 described that it was a witnessed fall. R49 fell right in front of the nurses station. I went to another residents room to help because the sensor alarm in that room was beeping. I remember hearing a sensor alarm go off near the nurses station but I was unable to go help since I was already assisting the other resident. I learned that R49 fell from a standing position after getting up from her wheelchair. I called the medical doctor (MD) to report the fall and the POA. R49 was taken to an acute care facility by ambulance. Prior to the fall R49 was restless, calling out to her family members a lot. We try very hard to keep the residents restraint free.

When asked what the protocol after a fall is, LPN90 replied that we assess them if its appropriate to keep them here. If there is significant injuries we call the Nurse Practitioner (NP). We assess what happened prior to the fall. Although the alarms help, if you cant get to the resident in time they can still fall. I know the staff here work very hard to get to those residents when their alarms are going off.

When asked after the fall what kinds of interventions were in place, LPN90 replied that our main goal was to keep her comfortable. The mat was ordered, she already had her care sense alarm in place. Staff monitored her closely, to make sure she wasn't doing the same thing again.

During an interview with the Administrator and DON, when asked how this fall could have been prevented, the DON stated that we don't have the ability to provide 1:1 supervision. The administrator added we could implement more frequent checks on the resident. From my

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experience, the lap belts don't necessarily stop falls. Especially if we don't want to restrain them. After the fall we had an IDT and resident care council (RCC). Physical Therapy (PT) will do an evaluation. I would like our facility to eventually stop using the chair alarms.

2) R30 is an 80 year old female resident diagnosed with Alzheimer's dementia and severe cognitive cognitive impairment and at risk for falls. R30 has had eight documented falls since being admitted to the facility on 12/05/18.

During an observation on 08/28/19 at 1:00 PM R30 stated, I got to get out of here, its too hot... she was restless and agitated, moving around in her bed. The bed was noted to be in the medium height position.

EMR reviewed.
Clinical notes reviewed.
Fall history:
A. 12/08/18: 07:35 staff found R30 on the floor with her head partially under the bed near the footboard. Noted a lump on the left aspect of lower occipital lobe and a lump & abrasion to right shin.
B. 12/10/18: Resident was hollering out and was found face down beside the bed, alarm tab still intact.
C. 01/16/19 R30 found on floor, no injuries.
D. 03/21/19 found on floor at 0925 AM. No injuries.
E. 03/22/19 found on floor at 0715 AM, no injuries.
F. 05/22/19 R30 found sitting on floor mat, no injury.
G. 05/26/19 R30 found kneeling on the floor mat, no injury.
H. 08/06/19 R30 found sitting on the floor mat,

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4 136	Continued From page 9 no injury. During an observation on 08/28/19 at 4:30 PM, noted R30 sitting in a semi fowler position in her bed. Bed at medium level height. Eyes open and alert. Care plan dated 12/05/18 to present reviewed. R30 is at risk for falls and injuries due to poor safety awareness and/ or impulsiveness related to dementia and unsteady balance. Interventions include: 1. Keep bed in the lowest position with wheels locked. 2. Monitor resident frequently in case she forgets to call for help. During the four days of the survey R30 was observed to have her bed in the mid level position. During an interview with LPN66 on 08/29/19, when asked how the residents are identified as having a high fall risk, she replied that it is in their Kardex and care plans. LPN66 did not know how residents are being identified to new staff or temporary staff without looking in the EMR. LPN66 stated that we check on the residents at least every two hours during rounds. 3) R40 is a paraplegic who does not have use of his lower extremities and limited use of upper extremities due to contractures to both hands. He requires the full assistance to transfer him into a wheelchair which is his primary mode of transfer. On 08/27/19 at 03:00PM during an interview with R40, he stated he likes to go to the lanai (patio) to smoke about three times a day and that he can smoke without supervision. He said, "this is my private time. " Asked R40 where he kept his	4 136		

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lighter and cigarettes, and he said, "I use to keep them in the pouch on the side of my wheelchair, but one of the resident's took them, so now I keep them with me, or in my room."

RR revealed R40's care plan documented he was at "Risk of injury due to smoking." The goal stated "Risks for self-injury related to smoking will be minimized. R40 will abide by the smoking policies of the facility." Interventions identified included the following:
a."Per resident's preference, R40 keeps his cigarettes and lighters on his person in his room. He is fully alert and fully cognitive and able to make his own decisions."
b. "Per medical physician (MD) orders, will continue to discourage R40 from smoking, but he continues to smoke against medical advice."
c. "R40 knows to smoke in only the designated smoking areas. If discovered smoking outside designated smoking boundaries, remind and encourage him in practice of appropriate policy guidelines of facility. Notify charge Licensed Nurse (LN), Director of Nursing (DON), or Social Service Worker (SSW) if inappropriate behavior."
d. "Smoking aprons are encouraged R40 is non-compliant. He prefers not to use a smoking apron."
e. "Monitor R40 for signs of burns in clothes, skin. Report to charge nurse and interdisciplinary team (IDT) if any evidence found."
f. "Monitor R40's ability to understand and practice good safety precautions during smoking."
g. " ...At this time, R40 is safe to smoke independently. IDT to perform smoking assessment annually and if experience change of condition."

Review of the facility policy dated October 2015,

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4 136	Continued From page 11 titled, " Smoking Policy" states "Smoking by residents shall be permitted if, after initial assessment by the IDT, it is determined the resident can safely handle a cigarette." The policy also states, "The assessment shall also include whether the resident is capable to storing and handling smoking materials independently. Residents deemed capable of storage and handling will be provided a locked bedside drawer. Residents deemed not capable will have smoking materials kept at the nursing station." RR of R40's, "Resident Smoking Assessment" dated 08/31/18 stated, "The resident must be evaluated with the following physical abilities to be permitted to smoke per facility policies and procedures." The facility identified 11 physical tasks "the resident must be able to perform ...to be permitted to smoke with supervision." R40 could not perform the following two of those physical tasks required. a. "Ability to touch thumb to each finger on each hand." This task was marked "N/A (not applicable" with the hand-written entry, "Joint contractures to both hands." b. "Ability to open and close index finger and middle finger is scissor motion with each hand." This physical task was marked "N/A" with the hand-written entry, "Joint contractures to both hands." The box "minimal assistance" was checked on the assessment form which was defined as "Resident exhibits physical ability to smoke with minimal assistance as evidenced by the evaluation of motor skills." On 08/28/19 at 12:05 PM R40 was observed smoking in the lanai area. He was in a motorized wheelchair and had a small cylinder ashtray resting on the right side of his abdomen propped	4 136		

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in place with a rolled-up washcloth. His lighter, cigarettes and two vaping products were also organized for access on his lap. While holding the cigarette in his mouth, observed R40 use both hands to light the cigarette. Because he wasn't able to hold the cigarrette with his contractured fingers, R40 used a hair comb with missing teeth to place the cigarette. He could hold the comb while he smoked. When R40 was done smoking he put the smoking product in the ashtray, which extinguished right away. R40 had no supervision while out in the lanai smoking.

On 08/29/19 at 09:34 AM during an interview with Social Worker (SW) asked if he was familiar with R40's smoking assessment. SW said he is "very familiar with the situation and that he works with resident's rights. The IDT monitors and reassesses every year."

Reviewed the facility policy titled, "Smoking Policy-Wailuku" revised date of October 2015. The policy states that," Smoking by residents shall be permitted if, after initial assessment by the IDT it is determined the resident can safely handle a cigarette." The policy also states, "The assessment shall also include whether the resident is capable of storing and handling smoking materials independently. Resident's deemed capable of safe storage and handling will be provided a locked bedside drawer. Residents who are not deemed capable will have smoking material kept at the Nursing Station and distributed ..."

On 08/29/19 at 11:27 AM during an interview with RN57, asked if R40 had a locked drawer in his room to store his cigarettes and lighter, and she replied, "I'm not sure." RN57 later reported that there was no locked drawer in R40's room and

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agreed that he would not be able to open a locked drawer due to the contractures in his hands. R40's smoking products were not secure and were accessible to any resident that wandered in to the room.

On 08/30/19 at 02:30 PM during an interview with the DON, she stated "R40 is due for his annual smoking assessment. We are going to be using a different assessment form..." The DON agreed that R40 was not able to perform all the physical tasks the facility had identified necessary to allow a resident to smoke safely without supervision.

II. Based on observation, record review and interview, the facility failed to ensure that residents who require dialysis, receive such services consistent with the professional nursing standards of practice, including accurate assessments of the resident's condition to monitor for complications of the arteriovenous fistula (AVF) (an access site in the arm for hemodialysis), specifically after HD treatments for one of one resident Resident (R)1 selected for review. R1 is at high risk for increased thrombosis (occlusions) and has a history of occlusions to his access site. Good post dialysis care of the AVF site is crucial to prevent negative outcomes that may result in the following: Occlusions; hemmoraging (bleeding out from the site) and/ or death. R1 did not receive professional nursing care of the site as evidenced by a licensed nurse who took blood pressures readings on R1's left (L) arm which has the AVF access site. Since R1 is at a high risk and has a history of occlusions, he should not have had blood pressure readings done on his left arm. In addition, the licensed nurse did not consistently document R1's post dialysis nursing assessment. This deficient practice, had the potential to cause

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4 136	Continued From page 14 serious harm and/ or death to R1, and any other resident residing in the facility who receives hemodialysis treatments. Findings Include: R1 is an alert and oriented resident who has a diagnosis of end stage renal disease and receives HD. During an interview with R1 on 08/27/19 at 12:22 PM, he said he goes out to receive HD treatments at an outside certified renal dialysis center on Mondays, Wednesdays and Fridays during the evening shift. R1 pointed to his left upper arm (LUA) and said his access site was there. He said it was an AV fistula. R1 also said he twice underwent surgery when it got clogged. They "had ballooned it" to open up the blockages in the AVF. R1 said he has no blockages to his access site at present. When asked whether the licensed staff checked the site when he returned to the facility he said "sometimes," and that staff did not always check him thoroughly, i.e., heart and lung sound assessments, AVF site assessment, vital signs check, etc. R1 said one thing he did know was that he would give the dialysis communication form to the nurses upon his return to the facility. He said that form had his HD treatment information which the dialysis staff completed each time he left the center. A sample review of R1's HD treatment record was done. It was found that R1's most recent HD treatments were on the following days: 08/28/19; 08/26/19; 08/23/19; 08/21/19; 08/19/19; 08/16/19 and 08/14/19. However, review of licensed practice nurse (LPN) 34's vital sign entries for R1 upon his return from	4 136		

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4 136	Continued From page 15 HD on "8/7/2019, 8/16/2019 and 8/21/2019," found her entries had "L Arm Sitting." LPN34 had documented that she was taking R1's blood pressure (BP) on the arm where R1's AV fistula access site was. There were two additional entries by LPN34 on the Vital Signs form for "8/9/2019 and 8/14/2019" which noted "Right (R) Arm Sitting." LPN34 was the only licensed staff on this form performing BP checks on R1's left arm from 07/15/19 to 08/28/19. The other licensed staff were documenting the BP checks were being done on R1's right arm. Vascular access fact sheet American Nephrology Nurses association (ANNA) 2018 states the AVF can provide good blood flow for many years of hemodialysis. Recent studies show that patients with AVFs have the least amount of complications such as infections or clotting...Caring for a Fistula. Good AVF care will help maintain the patency of the vascular access. Measures can be taken to prevent clotting or infection to the access...The access should be kept clean and free of injury or restriction to prevent clotting of the access... Not allow blood pressure to be taken in the access arm. The Fresenius Medical Care 2013, "NephroCare Patient Training Focus On: Fistula Care Protecting Your Lifeline," states to, "minimize the danger of infection or thrombosis, which are the most common dangers for your fistula . . . Avoid pressure of any kind on your fistula arm, as it can lead to thrombosis,... Measuring your blood pressure in the fistula arm with a blood pressure meter, as inflating the cuff induces a compression of the blood vessels . . .The mechanism of thrombosis can be activated by so-called 'hemodynamic mechanisms' such as low blood speed, change in temperature or changes in	4 136		

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blood pressure. The fistula arm of a dialysis patient is particularly vulnerable to these phenomena for a number of reasons. After repeated cannulations the fistula becomes sensitive and delicate.

In addition, within the "Resident Notes Report," there was no entry by LPN34 of the resident returning to the facility on "8/16/2019 22:02" (10:02 PM), except for a "L Arm Sitting" blood pressure reading of 114/62 found on the Vital Signs form. There also was no nursing entry in the Clinical Notes Report by LPN34.

On 08/29/19 at 02:09 PM, an interview with the Director of Nursing (DON) was done. The DON was queried what their standard of care was for her nursing staff to provide to residents returning from dialysis treatments. The DON stated she would expect her staff, "would be monitoring the site for vital signs, adverse bleeding, infection," and stated it would include the assessment of the bruit and thrill for a fistula.

The DON was informed that R1's HD days and the nursing entries did not coincide with the nursing assessments which she stated should be be done. An example included a 08/17/19 weekly skin assessment by a registered nurse which stated, "LUA AV shunt + bruit and thrill; no infection and bleeding noted. Lotion to dry skin. Cont to monitor weekly as ordered." However, R1 did not go for his HD treatment on 08/17/19 and went on 08/16/19, of which there was no nursing entry except for the sole blood pressure reading which LPN34 took on the resident's left arm.

There was a failure to identify, and consistently monitor R1's clinical record entries as well. The

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4 136	Continued From page 17 licensed staff failed to follow a 07/30/18 physician order which stated, "Monitor (L) Arm Fistula For Bruit & Thrill And Infection every (Q) Shift." This was not found to be done every shift in R1's clinical entries. As a result, the facility did not ensure R1 was provided with safe, consistent clinical assessments and monitoring post-HD treatments.	4 136		
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on interview and record review (RR), the facility staff failed to document and communicate pertinent information about an incident involving one of one Resident (R)68 sampled to other caregivers so interventions could be put in place to prevent a reoccurrence of a similar event. A family member of 68 attempted to feed her food she was not allowed. This put R68 at risk of aspiration or choking. The deficient practice of staff not communicating pertinent findings/events to other caregivers could affect any resident in the facility, and potentially affect the quality of care and safety of the residents. Findings include: RR revealed R68 was admitted to the facility on	4 148	4 148 Nursing Services Corrective Action This facility will ensure that staff communicate pertinent findings/events to other caregivers in the facility so that interventions are put in place to prevent reoccurrence and ensure quality of care and safety of our residents. Risk vs. Benefits was completed with POA regarding education of bringing in food outside of residents prescribed diet/texture on 08/29/19 by RN57. Care plan updated on 08/29/19.	10/4/19

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4 148	Continued From page 18 05/03/19. R68 had cognitive impairment due to dementia and had a recent stroke with left sided weakness. As result of the stroke, R68 had dysphasia (difficulty swallowing) and required the insertion of a gastrostomy tube (G-tube) through her abdomen wall and into her stomach for feeding. R68 received 100% of her nutritional needs through the G-tube. RR of the Speech Therapist (ST) Daily Treatment Notes revealed the following documentation: 05/27/19: "Trialed nectar thick liquids via cup. Edu (educated) pt. (patient) and husband on use of single sips, double swallow ..." 05/28/19: "Husband present for session. Facilitated trials of puree (Cream of wheat). Pt completing double swallow verbal cues. Edu pt. and husband on oral clearance strategies (double swallow ...)" 05/29/19: " ... Recommended pleasure feeds of puree and nectar liquids with use of double swallow and aspiration precautions. Informed nursing and provided written education on diet and strategies." After the ST evaluation, an order for "Puree (texture is a soft, pudding like consistency) and nectar (liquids of a consistency that drips off a spoon) pleasure feeds" by mouth was added to R68's diet. RR revealed a nursing clinical note in R68's record dated 08/14/19 by RN30 at 08:25 PM that read, "Spouse brought manapua (pork bun) from Costco tonight per resident's request. Per Power of Attorney (spouse), resident was unable to swallow couple of pieces because it "was too doughy: but resident sucked on the juice of the dish." RN30 did not document resident condition, a physical assessment or if education was provided to the spouse to prevent further events.	4 148	RN30 was provided 1:1 education on 08/29/19 No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. Responsible Person The Director of Nursing and Neighborhood Supervisors will be responsible for on-going compliance. Systemic Changes and Monitoring All staff will be in-serviced by 10/04/19 regarding the importance of communication of pertinent resident information. Any issues will be reported to morning stand-up and addressed immediately with identified staff. Date of Correction Compliance will be met by 10/04/19 and on an ongoing basis.	

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4 148	Continued From page 19 On 08/29/19 at 08:53 AM, during an interview with the Registered Dietician (RD)118, said she was not aware that the husband of R68 attempted to feed her food the texture she was not allowed. She stated, "R68 was a new admit and was on just tube feedings when she came. After ST evaluation, the puree and pleasure food were added. I know the spouse was involved and educated by ST." RD118 said. "If we had known, we could have done follow up with the spouse." On 08/29/19 at 03:03 PM during an interview with RN30, he said he recalled the incident when R68's spouse attempted to feed her a manapua. RN30 stated, "I did not see it, he came to me after and said he tried to give the manapua to her and she couldn't swallow it, so spit out a couple of bites. I assessed her, and she was fine, not in distress. I educated the spouse." RN30 said he did not recall if he recorded the incident for the next shift and agreed the clinical note he documented did not include pertinent information. On 08/29/19 at 03:33 PM during an interview with the Charge Nurse (RN57), she said she was not aware of the incident on 08/14/19. RN57 checked the desk calendar in the nursing station to see if there was a written note on that day. There was no notation on the calendar. RN57 stated, "The staff should pass that information on. In this situation, they should educate the spouse, do an assessment, document findings, and pass the information on to the Charge RN and next shift." RN57 said they communicate, by "writing it on the calendar for me to follow up the next day, and then tape record anything pertinent. The oncoming shift listen to the two previous shift tape recordings." RN57 did not recall the incident being recorded. When asked what RN57 would have done if she had been aware of the incident,	4 148		

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4 148	Continued From page 20 she replied, "If I had heard it, I would have called the spouse and remind him again and let him know what appropriate meals are. Remind him of the ST evaluation and risk for aspiration. If needed, I would do a Risk versus (vs) Benefit Form. Maybe if spouse is here, watch for what he offers her." On 08/30/19 at 10:31 AM during an interview with the Director of Nursing (DON), asked what she would expect from staff involved in this incident. DON said, "I would expect them to check the diet ordered, educate the husband, document the conversation, and follow up with any further education that might be needed such as RD, or involve administration who can decide if the Benefits vs Risks Form consent should be signed. I expect there would be communication to the charge nurse, and communication between shifts.	4 148		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference;	4 149		10/4/19

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4 149	Continued From page 21 (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the interdisciplinary team (IDT) fully assessed and determined a resident was capable of self-administering her medications for one of five residents Resident (R)43 in the sample of residents selected for medication administration review. This deficient practice had the potential to affect other residents who may be able to self-administer their medications. Findings Include: Observation on 08/29/19 at 08:06 AM found R43 in bed, holding onto tubing and doing her own nebulizer treatment. The registered nurse (RN)34 had prepared R43's morning medications to administer and entered the room to give them to the resident. The State Survey Agency (SA) queried how R43 started her treatment when RN34 had the albuterol vial in her possession for the medication administration with the SA to observe. On 08/29/19 at 08:15 AM, RN34 said R43, "always keeps a stock and it's the nurse who gives it." RN34 said this resident self administered her albuterol on her own. RN34 was asked whether licensed staff giving this	4 149	4 149 Nursing Services Corrective Action This facility will ensure that the Interdisciplinary Team (IDT) fully assesses and determines if a resident is capable of self-administering his/her medications. Resident R43 was determined by IDT to not be able to self-administer medications. All licensed staff will be in-serviced by 10/04/19 on Resident Rights and Safety in regards to self-administer medications. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. Responsible Person The Director of Nursing and Neighborhood Supervisors will be responsible for on-going compliance.	

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4 149	Continued From page 22 resident her albuterol vials tracked the number of the vials given to R43 and how it was monitored. RN34 said, "If we give something, we put it in the system and all as needed (PRN) ones also. We put it in a bedside drawer. She (R43) has an order to self administer and we actually watch her take it. She is very alert." R43's 2019 August medication order noted routine and as needed orders for: 1) albuterol sulfate 2.5 mg/3ml (0.083%) solution for nebulization (1 Vial) three times daily for shortness of breath, and 2) albuterol sulfate 2.5 mg/3ml (0.083%) solution for nebulization (1 Vial) . . . As Needed Every Four Hours for shortness of breath. A review of R43's care plan for her impaired respiratory function related to pulmonary fibrosis found interventions which stated the resident was able to independently operate her oxygen concentrator and nebulizer machine. But, it did not state the resident could self-administer any medications or keep them at her bedside. The intervention stated, "Administer inhaler(s) or nebulizer as ordered, and document effectiveness." Further review of R43's clinical record found there was no physician order for R43 to self-administer her albuterol sulfate medication via the nebulizer, nor for her to store the medication vials at her bedside. In addition, no documentation was found for any amount, date and time when the resident was given the medication vials for self-administration in the medication administration record (MAR), nor monitoring the effectiveness when the resident did her own treatments. There was no clinical documentation specific for this in R43's record.	4 149	Systemic Changes and Monitoring All staff will be in-serviced by 10/04/19 on Resident Rights and Safety in regards to self-administer medications. Facility policy is that no resident will be allowed to self-administer medications. Any issues will be reported to morning stand-up and addressed immediately with identified staff. Date of Correction Compliance will be met by 10/04/19 and on an ongoing basis.	

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4 149	Continued From page 23 On 08/29/19 at 09:20 AM, during an interview with R43, she said, "Yesterday they gave me one (vial) for this morning, because the nurses are sometimes late and I need to take it at eight o'clock. But they come at eight-thirty. And this morning the nurse said just call her." When R43 was asked if this was an on-going practice for the nurses to leave the albuterol medication vial at her bedside, she stated, "Only lately--not too long ago. They would give me one, whoever is the nurse--it's because we have all different people." She could not give a definitive time frame except it may have been more than a week ago that this practice of leaving the vials with her has been occurring. R43 said because she needs to take it, "three times a day and four hours apart, so if the nurse is late at 08:30, then the next one is 12:30 and I make sure the next one is every 4 hours after." R43 also said, "and when they found out here I could do it, they let me." She explained when she got a new albuterol vial from the nurse, she placed it in front of her small clock on her overbed table, "to remind me," and pointed to a vial already placed there for her next treatment. The facility's policy stated, "Medication Administration Self-Administration by Resident," at Section 7.3, "Policy Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe, . . . Procedures 1. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to	4 149		

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4 149	Continued From page 24 carry out this responsibility, during the care planning process, . . .The interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted as part of the care plan process . . . " During an interview with the Administrator on 08/29/19 at 11:24 AM, verified that R43, "has not been assessed for it," to self-administer her own medications, nor to keep her medications at bedside. In addition, the Administrator stated she did not find a physician's order for R43 to self-administer the albuterol sulfate routinely or as needed.	4 149		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently monitor one freezer's (number 10) temperature to ensure it was functioning properly for safe food storage. In addition, the facility staff failed to consistently monitor and record the dish machine final rinse temperature and did not always report it to the	4 159	4 159 Storage and handling of food Corrective Action This facility will ensure consistent monitoring of the freezer temperatures to ensure it is functioning properly for safe	10/4/19

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4 159	Continued From page 25 supervisor when the temperature was out of range. As a result of this deficient practice, the facility could not ensure the dishes were properly sanitized and ensure safe storage of food in freezer 10. This could potentially expose all residents to a higher risk for foodborne illness. Findings include: Review of the facility policy dated 04/02/13 titled, "Dish Machine Temperature Log" stated "Staff will be trained to record dish machine temperatures for wash and rinse cycles at each meal." The policy also stated, "Dishwashing staff will be trained to report any problems with the dish machine to the nutrition services supervisor as soon as they occur." Review of the facility policy dated 04/02/13 titled, "Cleaning dishes/Dish machine" directs staff to "Run one item through the machine and record the wash and final rinse temperatures on temperature log sheet. If ...the sanitizing rinse is less than 180-degree Fahrenheit (F), run another item through and test the temperature again. If still not within range, notify the supervisor or call maintenance repair line." Review of the dishwasher temperature log for August 2019 revealed the temperature of the dinner final rinse was not documented three times. It also revealed the dietary staff documented the final rinse was less than 180F 14 times with no documentation of a repeat temperature or notification to the supervisor. Review of the refrigerator/freezer temperature log, stated at the top of the log the safe freezer temperature range is less than zero degrees. The June 2019 temperature log for freezer 10, revealed no documentation the temperature was	4 159	food storage. This facility will ensure it consistently monitors and records the dish machine final rinse temperature and report any discrepancies to the supervisor when the temperature is out of range to ensure proper sanitization. All freezer temperatures are checked twice daily. All dishwasher temperatures are checked three times per day. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. Responsible Person Nutrition Services Manager will be responsible for on-going compliance. Systemic Changes and Monitoring Staff education was completed on 09/26/19 which included review of facility P&P's including "Dish Machine Temperature Log." Nutrition Services Manager will do daily checks of all temperature logs for 90 days or until 100% compliance. Interdisciplinary Team will conduct monthly	

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4 159	Continued From page 26 checked five times (June 11 AM, June 16 AM, June 19 AM, June 20 AM, and June 26 AM). On June 28th, the temperature was 28F and the unit was taken out of service. The food was relocated until the freezer was repaired. Review of the July 2019 temperature log for freezer 10 revealed the temperature was not documented 17.7% of the time (11 of 62 times). On 08/30/19 at 8:00 AM during an interview with the Director of Nutritional Services (DNS), reviewed the dish machine temperature logs. DNS stated she had a new employee working on the dish machine and felt the low temperatures may be because the new employee was taking the temperature at the beginning of the cycle. DNS confirmed there was missing documentation on the August dish machine temperature log and said she had not been notified on the 14 days that were documented to be out of range. DNS reviewed freezer 10 July temperature log, and stated, "that is the freezer located down the elevator and outside the building. It is the PM staff's responsibility to check the temperature. They usually check it when they go there to get something, but if they don't need anything, because of the location, they might forget."	4 159	focus rounds to ensure facility P&P is met regarding temperature logs. Any and all issues will be reported to daily stand up meeting as well as discussed monthly at Quality Assurance Performance Improvement Committee (QAPI) meetings. Date of Correction Compliance will be met by 10/04/19 and on an ongoing basis.	
4 166	11-94.1-42(d) Physician services (d) Physicians, physician assistants, or APRNs shall visit the facility as necessary to assure that adequate medical care is being provided, review plan of care, make pertinent recommendations, and determine appropriate level of care of resident.	4 166		10/4/19

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4 166	Continued From page 27 This Statute is not met as evidenced by: 1) Based on observation, record review and interview, the facility failed to ensure the interdisciplinary team (IDT) fully assessed and determined a resident was capable of self-administering her medications for one of five residents Resident (R)43 in the sample of residents selected for medication administration review. This deficient practice had the potential to affect other residents who may be able to self-administer their medications. Findings Include: Observation on 08/29/19 at 08:06 AM found R43 in bed, holding onto tubing and doing her own nebulizer treatment. The registered nurse (RN)34 had prepared R43's morning medications to administer and entered the room to give them to the resident. The State Survey Agency (SA) queried how R43 started her treatment when RN34 had the albuterol vial in her possession for the medication administration with the SA to observe. On 08/29/19 at 08:15 AM, RN34 said R43, "always keeps a stock and it's the nurse who gives it." RN34 said this resident self administered her albuterol on her own. RN34 was asked whether licensed staff giving this resident her albuterol vials tracked the number of the vials given to R43 and how it was monitored. RN34 said, "If we give something, we put it in the system and all as needed (PRN) ones also. We put it in a bedside drawer. She (R43) has an order to self administer and we actually watch her take it. She is very alert." R43's 2019 August medication order noted routine and as needed orders for: 1) albuterol	4 166	4 166 Physician Services I. Corrective Action This facility will ensure that the Interdisciplinary Team (IDT) fully assesses and determines if a resident is capable of self-administering his/her medications. Resident R43 was determined by IDT to not be able to self-administer medications. All licensed staff will be in-serviced by 10/04/19 on Resident Rights and Safety in regards to self-administer medications. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. Responsible Person The Director of Nursing and Neighborhood Supervisors will be responsible for on-going compliance. Systemic Changes and Monitoring All staff will be in-serviced by 10/04/19 on Resident Rights and Safety in regards to self-administer medications. Facility policy is that no resident will be allowed to self-administer medications.	

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4 166	Continued From page 28 sulfate 2.5 mg/3ml (0.083%) solution for nebulization (1 Vial) three times daily for shortness of breath, and 2) albuterol sulfate 2.5 mg/3ml (0.083%) solution for nebulization (1 Vial) . . . As Needed Every Four Hours for shortness of breath. A review of R43's care plan for her impaired respiratory function related to pulmonary fibrosis found interventions which stated the resident was able to independently operate her oxygen concentrator and nebulizer machine. But, it did not state the resident could self-administer any medications or keep them at her bedside. The intervention stated, "Administer inhaler(s) or nebulizer as ordered, and document effectiveness." Further review of R43's clinical record found there was no physician order for R43 to self-administer her albuterol sulfate medication via the nebulizer, nor for her to store the medication vials at her bedside. In addition, no documentation was found for any amount, date and time when the resident was given the medication vials for self-administration in the medication administration record (MAR), nor monitoring the effectiveness when the resident did her own treatments. There was no clinical documentation specific for this in R43's record. On 08/29/19 at 09:20 AM, during an interview with R43, she said, "Yesterday they gave me one (vial) for this morning, because the nurses are sometimes late and I need to take it at eight o'clock. But they come at eight-thirty. And this morning the nurse said just call her." When R43 was asked if this was an on-going practice for the nurses to leave the albuterol	4 166	Any issues will be reported to morning stand-up and addressed immediately with identified staff. Date of Correction Compliance will be met by 10/04/19 and on an ongoing basis. II. Corrective Action This facility will ensure that all residents are assessed by the attending physician with documented clinical notes for any increase in a psychoactive medication. R51 psychotropic medication regimen will be reviewed by provider by 10/4/19. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. Responsible Person The Director of Nursing and Neighborhood Supervisors will be responsible for on-going compliance. Systemic Changes and Monitoring All licensed staff will be in-serviced by	

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4 166	Continued From page 29 medication vial at her bedside, she stated, "Only lately--not too long ago. They would give me one, whoever is the nurse--it's because we have all different people." She could not give a definitive time frame except it may have been more than a week ago that this practice of leaving the vials with her has been occurring. R43 said because she needs to take it, "three times a day and four hours apart, so if the nurse is late at 08:30, then the next one is 12:30 and I make sure the next one is every 4 hours after." R43 also said, "and when they found out here I could do it, they let me." She explained when she got a new albuterol vial from the nurse, she placed it in front of her small clock on her overbed table, "to remind me," and pointed to a vial already placed there for her next treatment. The facility's policy stated, "Medication Administration Self-Administration by Resident," at Section 7.3, "Policy Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe, . . . Procedures 1. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care planning process, . . .The interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted as part of the care plan process . . . " During an interview with the Administrator on 08/29/19 at 11:24 AM, verified that R43, "has not been assessed for it," to self-administer her own medications, nor to keep her medications at	4 166	10/04/19 on the use of Psychotropic medications and the documentation requirements. Psychotropic committee will review each resident on a quarterly basis for appropriateness of psychotropic medication use, diagnoses, and documentation. Director of Nursing and/or Assistant Director of Nursing will conduct daily audits of any psychotropic medication changes to ensure proper consent, documentation and monitoring is in place. Audit will be done for 90 days or until 100% compliance. Any issues will be resolved immediately through communication with resident providers. Any identified trending issues will be discussed monthly at Quality Assurance Performance Improvement (QAPI) committee. Date of Correction Compliance will be met by 10/4/19 and on an ongoing basis.	

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4 166	Continued From page 30	4 166		

bedside. In addition, the Administrator stated she did not find a physician's order for R43 to self-administer the albuterol sulfate routinely or as needed.

2) Based on observation, record review and interview, the facility failed to ensure the resident was assessed by the attending physician with documented clinical notes for the increase in a psychoactive medication for one of five Residents (R)51 selected for review. This deficient practice had the potential to affect all residents receiving psychoactive medications.

Findings Include:

R51 was observed during the survey either sleeping and/or being assisted to eat by the nurse aides. Record review found the resident was on several psychoactive medications and a review of R51's drug regimen was done. R51 was found to be taking Seroquel 50 milligrams (mg) one daily, Seroquel 25 mg one daily, Ativan 0.5 mg one daily and Lexapro 10 mg one daily. R51's diagnoses included vascular dementia with behavioral disturbances, acute right cerebellar stroke, anxiety disorder and a brain stem stroke syndrome, amongst others.

Review of the provider's notes however, did not show an entry by the physician to have assessed or provided a rationale to add Seroquel 50 mg one time daily (ordered 05/29/19 and started 05/30/19). The last physician progress note about the resident's behaviors and use of antipsychotics was dated 09/13/18, regarding the subject of travel when R51's family was interested in taking the resident home to the Philippines.

On 08/29/19 at 01:20 PM, during an interview

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4 166	Continued From page 31 with the Assistant Director of Nursing (ADON) of their other facility, she stated their current electronic record review did not show the current physician reports. On 08/29/19 at 01:51 PM, the ADON verified she could not find anything where the physician made an entry/note to explain the increase in R51's Seroquel dose.	4 166		
4 183	11-94.1-45(b) Dental services (b) Each resident or resident's legal guardian, or surrogate shall select the dentist of his or her choice, and the facility shall assist each resident to obtain necessary dental care by making arrangements for appointments and transportation, as requested. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to assist the resident with a timely dental referral for one Resident (R)44 who needed dentures. This deficient practice violated the residents right to quality care. Findings include: During an observation and interview with R44 on 08/27/19 at 09:30 AM, in room 141 R44 stated that she was waiting to get her dentures for two months. R44's upper teeth were noted to be edentulous. R44 stated that she wondered when she would get her denture. Progress note dated 06/25/19 reviewed. Patient stated to the nurse practitioner (NP) that she is upset about her teeth and feels embarrassed to be seen by family without dentures. Waiting on dental and social work to arrange it so that she can receive oral care and be fitted for dentures.	4 183	4 183 Dental Services Corrective Action This facility will ensure that all residents are assisted with a timely dental referral and ensure residents rights to quality care. Resident admitted to facility on 03/21/19. Resident request for dentures and dental referral by Social Services Assistant done on 04/03/19. Resident seen by RDH on 07/18/19 and scheduled to be seen by Dr. Orikasa on 9/18/19. No residents were identified to have been affected by this deficiency.	10/4/19

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4 183	Continued From page 32 Progress notes reviewed dated 06/26/19: Social services (SW). Contacted Hui No Ke Ola Pono, Inc. (HNKOP), (a health management and health care referral agency for the community of Maui). HNKOP staff confirmed the application for dental services was on file and not sure why there was a delay in services being scheduled. The SW requested that HNKOP contact resident as soon as possible to provide update to services and schedule an appointment.	4 183	All residents have the potential to be affected by this deficiency. Responsible Person Neighborhood Supervisors and Social Services Designee will be responsible for on-going compliance. Systemic Changes and Monitoring All residents are reviewed quarterly and as needed for a need for routine dental services. Appropriate referrals are made timely to facility contracted dental service or resident selected community dentist. Date of Correction Compliance will be met by 10/04/19 and on an ongoing basis.	